

Topic 10 — Can you get pregnant from...

Introduction

It's hard to know the exact numbers of pregnancies among teenage women as abortion data is not recorded and reported in every state and territory. The national rate of babies born to teenagers has dropped, from 4.6% in 2003 to 3.6% in 2012. In South Australia, where both births and abortion rates are recorded, births and abortions among teenage women have fallen even more significantly. In 2002 there were 43.9 births per 1000. In 2012, the figure was 29.1. This is a drop of 30%. Abortion rates fell from 24.8 per 1000 teenage women in 2002, to 13.7 in 2012. These reductions have been attributed to targeted sex education programs in schools, along with increased use of long acting contraceptive devices, such as contraceptive skin implants (SA Health, 2012).

While not all teenage pregnancies are unwelcome, early parenthood is linked to decreased opportunities for education and income, especially for girls and their children. Some young people are more likely to become pregnant in their teens than others: young women with disabilities, indigenous young women, young women living in disadvantaged areas and remote areas, and young women who identify as same-sex attracted (ABS, 2014; Hillier et al 2005). Victims of sexual abuse are more likely to have early and unprotected sexual activity and to become pregnant. We do not know the rates of teenage men whose female sexual partners have become pregnant. Clearly social and economic inequality and other structural factors are integral to a young person's options and life expectations.

While a single intervention is unlikely to provide The Answer, school-based programs make a significant difference. How?

- First, when our broader educational goals enable disadvantaged young people to be included in the opportunities and advantages of living in an economically advanced society.
- Second, because our relationships and sexuality programs can help young people delay sex until they are older, when they are more likely to use contraception (UNESCO, 2009).
- Next, because our classroom programs can address the barriers to contraception and health services by increasing knowledge of effective options, challenging the shaming of girls who seek information eg the phenomenon of calling contraceptive skin implants 'slut sticks', and by inviting local health providers into our classrooms.
- Last, by including boys in the conversation so that they understand

their contribution to the prevention of pregnancy. Boys are less likely to receive education targeted to them in relation to teenage pregnancy. Parents are much less likely to talk to their sons about avoiding a teenage pregnancy. Boys' actions and attitudes can improve the use of contraception and reduce the risk of unintended pregnancy (WHO, 2011).

Activities

- 1: Jessica and Ashley
- 2: Conception revision
- 3: Contraception – an overview of facts and stats

Time

120 minutes

Handouts

- *H1: Jessica and Ashley's story*
- *H2: Winding back the clock cards.*
- *H3: FAQs From Young People About Getting Pregnant*
- *H4: Information about Contraception*
- *H5: Information Sheet - Contraception: Success and Failure Rates of Contraceptives*

Slides

- Slide presentation, *S1: Contraception – an overview of facts and stats*

ACTIVITY 1: JESSICA AND ASHLEY

Time: 20 minutes

Overview: This activity begins with a case study. Students identify common barriers as well as first-step solutions to using contraception. The students are required to think through how individuals, services and institutions could make it easier for young people to use contraception.

Jessica and Ashley's story reflects the reasons most often identified by young people for not using contraception or contraception failure. They are:

- Difficulty getting contraception (the most frequent reason),
- lack of intention to have sex,
- the misconception that they "could not get pregnant."
- using condoms incorrectly, or forgetting to take oral contraceptives.

(Biggs, Karasek, & Foster, 2012).

Key Messages

- There can be barriers for a young person to organise contraception but there are some strategies they can use to help.
- A person's health is often affected by circumstances outside their individual responsibility, such as a communities' efforts to increase young people's access to contraception.
- Contraception is the responsibility of young men as well as young women.

Preparation and Materials

- *H1: Jessica and Ashley's story*
- *H2: Winding back the clock* cards. There are 6 different cards: (1) Jessica; (2) Ashley; (3) Jessica's Mum; (4) Health providers; (5) Jessica's school; (6) 'Society'

Method

1. Ask for an enthusiastic reader to read *H1: Jessica and Ashley's story* to the whole group.
2. Organise students into 6 groups. Give one *H2: Winding back the clock* card to each group. The groups must answer the questions on the cards,

from the perspective of the character or institution identified. They are to come up with a plan for preventing the situation Jessica and Ashley are in. They must also come up with an 'after the event' plan, to assist their character/institution to handle the situation now.

3. Once plans have been developed, organise for groups to read and share their 'before' and 'after' plans.
4. Debrief

ACTIVITY 2: CONCEPTION REVISION ACTIVITY

Time: 60 minutes

Do your students understand how conception occurs? Helplines for young people report often getting the question *'Can I get pregnant from...'* or *'I didn't think she could get pregnant if she had her period/it was the first time/he pulled out before he came...'*

As a simple and fun revision, ask the students to draw a large picture on butchers' paper, one of the male sexual and reproductive systems, the other of the female sexual and reproductive systems. They can either do this individually or in relay teams. Give them a time limit.

They must include the following:

- As many labeled parts of the systems that they can;
- Label where sperm is produced;
- Label where ova/eggs are;
- Draw the journeys of the egg (during ovulation) and sperm through their respective systems.
- Draw how conception occurs. Then they must sketch in how sperm leaves the male body, enters the female body, how the egg and sperm meet.

Compare students' results with labeled illustrations of the systems or go to this QLD health page for excellent animated slides: www.health.qld.gov.au/clinical-practice/guidelines-procedures/sex-health/animations/reproductive-cycle.swf

ACTIVITY 3: CONTRACEPTION — AN OVERVIEW OF FACTS AND STATS

Time: 40 minutes

Overview: This presentation is an overview of research. It aims to increase students' knowledge about the range of contraception and which choices are most suitable for young people. Secondly, students will consider the personal and social barriers to contraceptive use by young people.

Key Messages

- There are many different types of contraception that vary in how effective they are at preventing pregnancy.
- Contraception is the responsibility of both partners. Young men and women should be given accurate information about contraception, STIs and unplanned pregnancy to help them make informed decisions.
- There are good sources of information about contraception.
- Different types of contraception work better or worse for individuals. It is great if a person can find a good health care provider to discuss the different options.

Preparation and Materials

- Find out names and numbers of local services that provide contraceptive information for young people.
- Slide presentation, *S1 - Contraception – facts and stats*
- Copies of *H4: Information about Contraception*, 1 per student.
- *H5: Information Sheet - Contraception: Success and Failure Rates of Contraceptives*

Method

1. Tell the students that you will have a presentation on contraception, pregnancy statistics and contraceptive use in Australia. This session focuses on checking students' knowledge.
2. Let them know that the session will conclude with sources of information for follow-up for anyone who wanted to know about

contraception or was seeking contraception.

3. Make sure students are aware of opportunities for questions in private, and whom to go to in your locality.
 - Present Slide presentation, *S1: Contraception – facts and stats*. The data is interspersed with discussion questions so that students can predict results or reflect on the implications. The final slide asks students to predict which are the most effective contraceptives.
4. Have students form pairs, and distribute the worksheet *H4: Information about Contraception* to each pair. Make sure all students get a copy so they can take them home.
5. Explain the difference between 'Typical use' rates vs 'Perfect use'. See the Information Sheet - *Contraception: Success and Failure Rates of Contraceptives* for the definitions.
6. Ask the students to predict and tick the three most effective forms of contraception to prevent pregnancy, according to 'typical use'.
7. Follow up by distributing the information sheet *Contraception: Success and Failure Rates of Contraceptives* so that students may check their own answers.

H1: JESSICA AND ASHLEY'S STORY

Jessica and Ashley have been going out together for a few months. They met at Ashley's sister's party. Jessica is still at school (she's 16). Ashley is three years older and has an apprenticeship. Ashley has had a few girlfriends before. Jessica has not really had a 'proper' boyfriend before.

Jessica really likes Ashley. They laugh a lot and go out every weekend and kiss and fool about. Jessica is really happy with it that way, although they both begin to think they'd like to have sex with each other. Ashley definitely would. He's tried a few times to go further but Jessica wants to organise contraception first. Ashley says he'll pull out in time but she knows that's a really unreliable way to prevent pregnancy.

Jessica would like to go to the doctor, but the receptionist is a friend of her Mum. Jessica's worried her Mum would find out. Jessica's mother has never talked with her about sex and contraception but Jessica is pretty sure she wouldn't be very happy for her to start having sex. Plus, she doesn't want to be stopped from going out with Ashley.

One night Jessica and Ashley go to a party and they both have a fair bit to drink. They go out to his car and start kissing and before they know it they've had sexual intercourse. Ashley tried to put a condom on, but he couldn't roll it on and started to lose his erection, so they threw the condom away. Jessica was kind of thinking about pregnancy in the back of her head but she just wanted to get 'it' over and done with.

The next day Jessica starts to worry about pregnancy.

She tells her best friend that she's worried, and her friend advises her go and get Emergency Contraception. Again, Jessica is too ashamed and frightened to go to the chemist. She's worried they will be disapproving and send her away. She doesn't want the people in the chemist shop judging her, so she doesn't go. She texts Ashley to say she's worried about pregnancy but he says no-one ever gets pregnant the first time they have sex.

Jessica might be pregnant. She is worried. She doesn't want to be pregnant. Ashley is not too worried, but his girlfriend may be pregnant.

Jessica

- If you could wind back the clock so that Jessica could start over, what three pieces of advice would you give her to help her prevent this situation?
- Think of three pieces of advice to help Jessica deal with her needs after this has happened.



Ashley

- If you could wind back the clock so that Ashley could start over, what three pieces of advice would you give him to help him prevent this situation?
- Think of three pieces of advice to help Ashley deal with his needs after this has happened. Consider whether Ashley understands how pregnancy occurs.



Jessica's Mum

- If you could wind back the clock so that Jessica's Mum could start over, what three pieces of advice would you give her to help her prevent this situation?
- Think of three pieces of advice to help Jessica's Mum deal with this now.

Health providers

- If you could wind back the clock so that the local health care providers, including the chemist, doctors could start over, what three pieces of advice would you give them to help prevent this outcome? Could they do anything?
- Think of three pieces of advice to give to health care providers so they can help Jessica deal with her needs after this has happened.



Jessica's school

- If you could wind back the clock so that the Jessica's school could start over, what three pieces of advice would you give the school to help prevent this outcome? Could the school do anything?
- Think of three pieces of advice to give to the school so they can help Jessica deal with her needs after this has happened.



'Society'

What about the big picture? What three things might be changed in 'society' (which could mean government rules, media content, gender roles, poverty, life opportunities etc) that are consistent with human rights that would help prevent this situation?

H3: FAQs FROM YOUNG PEOPLE ABOUT GETTING PREGNANT

How often does an egg leave the ovary?

Approximately every 28 days, but it can vary from every 20 days to longer.

Is there such a thing as a safe time to have sexual intercourse?

Ovulation (the maturation and release of an egg from the ovary) generally occurs around halfway through a cycle. So if a woman has a 28-day cycle (that is, her periods start every 28 days), then the egg will probably be released halfway through the cycle (which in a 28 day cycle is 14 days from the start of her period). If the next time she has a period it is only a 20-day cycle, then ovulation probably occurred on Day 10. It is very hard for young women to know when an egg has been released from the ovary (in other words, when ovulation has occurred) as the length of her cycle is very changeable in the early years of menstruation.

If she had penis-vagina sex and she had not ovulated (that is, there is no egg hanging around in the Fallopian tubes or uterus) then there is no pregnancy. **However**, sperm can stay viable for 5 days once inside the uterus and fallopian tubes, so if she ovulates in the 5 days after she had penis-in-vagina sex then this could result in a pregnancy. Natural methods of contraception have a very high failure rate for young women.

How long does sperm survive inside the other person?

5 days.

Can pregnancy occur during a girl's period?

Yes – it's hard to predict if one egg is still 'viable' or if another one may be present.

How could a girl become pregnant if he pulled out before he came?

There is a small chance that his pre-cum contains some sperm and this may enter her vagina. Apart from possible presence of pre-cum, pulling out 'in time' is very hard to achieve. It is not a highly effective method of contraception.

If his penis did not go into her vagina, but he ejaculated outside her vagina, could she become pregnant?

Yes. It's a small chance, but if his semen got onto the opening of her vagina then

it is theoretically possible that sperm could enter into her vagina. It's highly unlikely, but possible.

If his penis did not go into her vagina, but he ejaculated outside her vagina, could she become pregnant?

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Can you get pregnant from anal or oral sex?

No. A person could get an STI including a blood borne virus, but not become pregnant. For a person to become pregnant the sperm must meet the egg.

Adapted from http://www.scarleteen.com/article/bodies/where_did_i_come_from_a_refresher_course_in_human_reproduction

S1: CONTRACEPTION FACTS AND STATS

WHAT PERCENTAGE OF AUSTRALIAN SECONDARY SCHOOL STUDENTS AGED 15 TO 17 REPORTED BECOMING PREGNANT OR THEIR FEMALE PARTNER BECOMING PREGNANT?

- 5% of sexually active students had sex that resulted in pregnancy.
- Students in year 10 (8%) were more likely than those in year 12 (2%) to report a pregnancy.

Source: Mitchell et al., 2014

S1: CONTRACEPTION FACTS AND STATS

ARE NUMBERS OF TEENAGE PREGNANCIES AND ABORTIONS IN AUSTRALIA INCREASING OR DECREASING?

In South Australia (one of the states that records both live births and abortion rates among 15-19 year olds):

- There were 44 births per 1000 teenage women in 2002.
- This has dropped to 29 births per 1000 teenage women in 2012 .
- There were 25 abortions per 1000 teenage women in 2002.
- This has dropped to 13.7 in 2012.
- Teenagers now account for just 3.9 per cent of all women who gave birth, which is the lowest rate ever recorded in SA.

S1: CONTRACEPTION FACTS AND STATS

WHY ARE THE NUMBERS OF PREGNANCIES DECREASING? THEORIES?

- In Australia the use of contraception at the time of first sex is high and has increased over time. Young people are more likely to use contraception than they were in the past.
- These changes have been attributed to sex education and more contraceptive choices.
- Increased use of Long Acting Reversible Contraception (LARC), instead of the Pill.

S1: CONTRACEPTION FACTS AND STATS

WHY MIGHT LARCS (EG IUDS, INJECTIONS AND IMPLANTS) BE MORE EFFECTIVE THAN OTHER METHODS OF CONTRACEPTION?

LARCs are more effective for young women having sexual intercourse with men, if they have trouble remembering to take pills or use condoms all the time.

S1: CONTRACEPTION FACTS AND STATS

WHAT ARE THREE REASONS THAT YOUNG WOMEN GIVE FOR NOT USING CONTRACEPTION?

- Difficulty getting contraception including getting contraception prescriptions (the most frequent reason)
- Being unprepared and not expecting sex “it just happened”
- The mistaken belief that “i didn’t think i would get pregnant” eg “i didn’t think i would get pregnant the first time i had sex” or “ i didn’t think i would get pregnant if i had sex during my period”
- In other cases, contraception was used, but often incorrectly, specifically forgetting to take the pill every day, or not using condoms every single time.

Source: Martinez & Abma (CDC), 2015

S1: CONTRACEPTION FACTS AND STATS

HOW CAN BOYS WHO HAVE SEXUAL INTERCOURSE WITH GIRLS MAKE A DIFFERENCE TO PREVENTING UNINTENDED PREGNANCIES?

Studies show that boys can make a big difference in preventing unplanned pregnancy:

- Using condoms all the time
- Talking with their partner about preventing pregnancy.

“My boyfriend mentioned it recently. He said ‘how should we make sure you don’t get pregnant when we have sex?’ I was really pleased I didn’t have to bring it up – that he feels responsible for it too and he’s serious about us.’

“We talked about it at school and straight away I called my girlfriend and told her that we needed to sit down and talk about ‘being safe’, I hadn’t really thought it was up to me to do it before’.

S1: CONTRACEPTION FACTS AND STATS

HOW CAN PARENTS AND CARERS, AND EDUCATION PROVIDERS, SUPPORT BOYS?

- Traditionally the focus of pregnancy education has been on girls. Boys are often less likely to receive sex education about preventing pregnancy, both at school and at home.
- 16-18 year old boys whose parents are open about sex and contraception are more likely to talk with their sexual partners about using contraception.
- Teenage boys in the Netherlands are 2 to 3 times more likely to discuss contraception with their sexual partners than teenagers in the United Kingdom, and parents are twice as likely to discuss sex with their children.

Source: Stone and Ingham, 2002

S1: CONTRACEPTION FACTS AND STATS

TALKING ABOUT USING A CONDOM OR AVOIDING PREGNANCY USUALLY MEANS THAT PEOPLE ARE MORE LIKELY TO USE A CONDOM, OR OTHER CONTRACEPTION. IT MAKES IT EASIER TO DO.

Year 10 and Year 12 students were asked: Think back to the last time you had sex. Before you had sex, did you talk to this person about...

- having sex (81%),
- using a condom (69%),
- avoiding pregnancy (50%) and
- how to gain sexual pleasure without having intercourse (40%)

Source: Mitchell et al., 2014

S1: CONTRACEPTION FACTS AND STATS

WHICH CONTRACEPTIVES ARE MOST EFFECTIVE?

Year 10 and Year 12 students were asked The last time you had sex which, if any, forms of contraception did you or the person you had sex with use?

They said:

- Condom 58%
- Contraceptive pill 39%
- Withdrawal method 15%
- Emergency contraception only 4% of students

S1: CONTRACEPTION FACTS AND STATS

EMERGENCY CONTRACEPTION IS AN IMPORTANT FORM OF CONTRACEPTION. IT HAS RECENTLY BEEN MADE LEGAL TO DISTRIBUTE TO 16 YEAR-OLDS IN SCHOOLS IN FRANCE. SHOULD WE MAKE EMERGENCY CONTRACEPTION AVAILABLE AT SCHOOLS IN AUSTRALIA?

Emergency contraception must be taken as soon as possible after unprotected sex, and is recommended to be taken within 3-5 days. A person does not need a prescription for it.

Emergency contraceptive pills (ECPs) work before pregnancy takes place by preventing the release of an egg (ovulation) or by stopping the egg and sperm from meeting. They do not harm a developing embryo.

Young women under the age of 16 are able to access the emergency contraceptive pill from a chemist/pharmacy.

For good information about EC watch:
Louna's Lowdown on Emergency Contraception

H4 INFORMATION ABOUT CONTRACEPTION

from the Royal Women's Hospital, Melbourne

The following is a brief description of contraception choices.

THE MALE CONDOM

Effectiveness rates: PERFECT USE ___ % TYPICAL USE ___%

The male condom is a fine rubber or synthetic sheath that is worn on a stiff (erect) penis. It collects the sperm and stops them entering your vagina and uterus. You can buy condoms from a chemist or supermarket. Condoms reduce the risk of both pregnancy and sexually transmitted infection.



DIAPHRAGMS

Effectiveness rates: PERFECT USE ___ % TYPICAL USE ___%

A diaphragm is a soft silicone cap worn inside the vagina to cover the entrance to the uterus (the cervix). It stops the sperm from getting into the uterus. A diaphragm can be used at any time, even during your period, and can be washed and used over and over again. A diaphragm has to be put in before having sex (up to 24 hours before) and removed after sex.



THE PILL

Effectiveness rates: PERFECT USE ___ % TYPICAL USE ___%

Even though we use the expression ‘the Pill’, there are actually two main types of oral contraceptive pills.

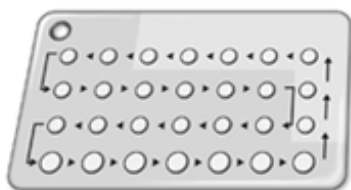
The combined pill

This pill has two hormones, which stop the ovaries releasing an egg each month. You still bleed each month but not as much as usual. The combined pill can also bring relief for acne and premenstrual syndrome. Some women will have side-effects such as bloating, nausea, and minor weight gain.

The progestogen-only pill (mini pill or POP)

This pill has only one hormone and works by changing the mucus at the entrance to the womb (uterus) so that sperm cannot pass through to fertilise the egg.

The progestogen-only pill is different to the combined pill because it doesn’t stop ovulation. If mistakes happen, such as missed pills, around one in ten women may get pregnant.



THE VAGINAL RING

Effectiveness rates: PERFECT USE ___ % TYPICAL USE ___%

The vaginal ring contains the same two hormones that are in some types of the Pill. It works in the same way as the Pill to prevent an egg being released each month. The ring is placed high in the vagina and left in place for three weeks. It is removed for one week to allow you to have a regular monthly bleed. Like the Pill, 1 in 10 women (10 per cent) using a vaginal ring may get pregnant.



EMERGENCY PILL

(sometimes called the 'morning after pill')

If you had sex without contraception, or you were using a condom that broke, you can take an emergency pill, which will prevent a pregnancy from happening.

Emergency pills are available from the chemist with no prescription. They must be started within three days (72 hours) after unprotected sex and they work best if taken as soon as possible after sex.



THE CONTRACEPTIVE INJECTION

Effectiveness rates: PERFECT USE ___ % TYPICAL USE ___%

DMPA (also called Depo Provera or Depo Ralovera) is an injection of a long-acting synthetic hormone. Women have the injection every 12 weeks for contraception. It can be used when breastfeeding. Some women will have side-effects, such as mood changes, tummy discomfort and headaches, which can last for up to 12 weeks.



CONTRACEPTIVE SKIN IMPLANT

Effectiveness rates: PERFECT USE ___ % TYPICAL USE ___%

This is a small plastic rod, which is inserted underneath the skin on the inside of the upper arm. It slowly releases the synthetic hormone progestogen, which stops the ovaries releasing an egg each month. Most women will have a different bleeding pattern and some stop bleeding altogether. Some women will notice skin changes, mood changes or minor weight gain. It will last for three years and is a very effective method for preventing pregnancy (99.95 per cent effective).



INTRA UTERINE DEVICE (IUD)

Effectiveness rates: PERFECT USE ___ % TYPICAL USE ___ %

This is a small contraceptive device that is placed in your uterus. There are two kinds of IUD:

- copper IUD – lasts five to ten years
- progestogen IUD – lasts for five years

The IUD affects sperm movement and survival in the uterus (womb) so that they cannot reach the egg to fertilise it. The IUD also changes the lining of the womb (endometrium) so that it is not suitable for pregnancy. This prevents a fertilised egg from developing.

It is very effective long-term contraception.



STERILISATION

Effectiveness rates: PERFECT USE ___ % TYPICAL USE ___ %

Both men and women can have an operation to make them sterile. The woman's operation involves blocking the fallopian tubes. It is done through the abdomen and is called a tubal occlusion and tubal ligation. The male operation is called a vasectomy. This method is for people who have already had all the children they want.

There are also now tiny inserts that can be placed inside a woman's tubes by means of a special instrument. This procedure is done through the vagina and can be done while the woman is awake.

NATURAL METHODS OF CONTRACEPTION

Effectiveness rates: PERFECT USE ___ % TYPICAL USE ___ %

The rhythm or Billings methods, fertility awareness, mucus, ovulation and temperature methods all provide ways for you to monitor where you are at in your cycle and when you are fertile. These methods are most effective when you have regular periods. If they are done perfectly these methods are between 95 to 99.6 per cent effective. However, 5 in 20 women (25 per cent) may get pregnant using these methods.

WITHDRAWAL

Effectiveness rates: PERFECT USE ___ % TYPICAL USE ___ %

This is when the man takes his penis out of the vagina before he ejaculates and sperm is released from the penis. This doesn't work if he forgets to withdraw his penis or is not quick enough. Also there may be some sperm in the pre-ejaculate (fluid that comes out of his penis before he ejaculates). If he ejaculates at the entrance to the vagina some sperm may still swim inside and a woman could still get pregnant with this method.

Where to get more information

Not all types of contraception are suitable for all people. Sometimes the doctor or nurse will ask a few questions about a person's medical and family history to help them decide which method is most suitable.

Young people who are worried about getting information are often welcome (in youth-friendly services) to a parent or carer, a friend or partner. That way two people both get the facts straight right from the start – and talking about it afterwards is a lot easier.

- Your local doctor (GP)
- Your local pharmacist
- Family Planning

This information has been reproduced with kind permission from the Royal Women's Hospital Melbourne.

More info: www.thewomens.org.au/health-information/contraception/

H5 INFORMATION SHEET - CONTRACEPTION: SUCCESS AND FAILURE RATES OF CONTRACEPTIVES

Contraception: Success and Failure Rates of Contraceptives

<http://youngwomenshealth.org/2009/11/03/success-and-failure-rates-of-contraceptives/>



These charts show the percentages of women who accidentally get pregnant while using contraception over the course of one year.

Typical Use: Typical use is what happens in real life, such as when people forget to use a condom or didn't put it on right; or forget to take the Pill everyday.

Perfect Use: When contraception is used every time, and it is used according to instructions each and every time.

When you're considering which type of contraception to use, it's helpful to look at the typical-use rate. Then, try to be honest with yourself and decide whether you should move closer to the perfect-use rate or further away.

Using more effective methods is one approach. As mentioned, a long-acting reversible contraceptive, such as an implant or IUD, has a great pregnancy-rate track record. If long-acting methods are not an option and you and your partner are not 'perfect users' then another option is to use two methods simultaneously, an approach taken by 15 percent of men and women.

Male Condoms	
Out of 100 Women Using Male Condoms:	
Typical Use: 18 Women Become Pregnant	
Perfect Use: 2 Women Become Pregnant	

Withdrawal

Out of 100 Women Using Withdrawal:

Typical Use: 22 Women Become Pregnant



Perfect Use: 4 Women Become Pregnant



Birth Control Pills — Combination

Out of 100 Women Using Combination Birth Control Pills

Typical Use: 9 Women Become Pregnant



Perfect Use: 1 or Fewer Women Become Pregnant



Birth Control Pills — Progestin-Only

Out of 100 Women Using Progestin-Only Birth Control Pills

Typical Use: 9 Women Become Pregnant



Perfect Use: 1 or Fewer Women Become Pregnant








The Contraceptive Injection — Depo Provera



Out of 100 Women Using Hormonal Injections:

Typical Use: 6 Women Become Pregnant



Perfect Use: 1 or Fewer Women Become Pregnant	
Contraceptive Skin Implants	
Out of 100 Women Using Contraceptive Skin Implants	
Typical Use: 1 or Fewer Women Become Pregnant	
Perfect Use: 1 or Fewer Women Become Pregnant	

Vaginal Ring	
Out of 100 Women Using Vaginal Rings	
Typical Use: 9 Women Become Pregnant	
Perfect Use: 1 or Fewer Women Become Pregnant	


Diaphragm	
Out of 100 Women Using Diaphragms	
Typical Use: 12 Women Become Pregnant	
Perfect Use: 6 Women Become Pregnant	


IUD (Intrauterine Device)	
Out of 100 Women Using IUDs	
Typical Use: 1 or Fewer Women Become Pregnant	

Perfect Use: 1 or Fewer Women Become Pregnant	
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Female Sterilization



Out of 100 Women Using Female Sterilization

Typical Use: 1 or Fewer Women Become Pregnant	
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Perfect Use: 1 or Fewer Women Become Pregnant	
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Natural Methods

Out of 100 Women Using Natural Methods

Typical Use: 24 Women Become Pregnant	 
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Perfect Use: 1-5 (average 3) Women Become Pregnant	
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No Methods

Out of 100 Women Using No Contraceptive Method

Typical Use: 85 Women Become Pregnant	
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